STATE OF NEVADA

THE FUND FOR A HEALTHY NEVADA

2003-2008 EVALUATION PLAN

June 2003

Prepared By:

6121 Lakeside Drive, Suite 160
Reno, Nevada 89511
Phone: (775) 324-4567
Fax: (775) 324-4941
Internet: www.socialent.com

1330 21st Street, Suite 100
Sacramento, California 95814
Phone: (916) 930-9200
Fax: (916) 930-9010
www.centerforhealthimprovement.org

ACKNOWLEDGEMENTS

A number of stakeholders interested in the health and welfare of Nevadans participated in the development of this evaluation plan. As such, we acknowledge and thank the Fund for a Healthy Nevada Task Force, Legislative Council Bureau (LCB) staff, Fund for a Healthy Nevada staff, the Department of Human Resources, and members of the Statewide Evaluation Team (SET). Funding for the project was provided by the Task Force for the Fund for a Healthy Nevada.

Task Force Members (through June 2003):

Senator Raymond D. Rawson, Chairman

Assemblywoman Vivian L. Freeman, Vice Chairman

Assemblywoman Kathy McClain

Ms. Maureen Brower

Dr. John Ellerton

Dr. Elizabeth Fildes

Mr. Ron Mestre

Ms. Carla Sloan

Mr. Bill Welch

Statewide Evaluation Team Members:

Ms. Gina Byrge

Ms. Terri Clark

Dr. Tyree Davis

Ms. Cynthia Freeman

Mr. Mike Johnson

Ms. Theresa Lemus

Ms. Barbara Ludwig

Ms. Michele Oke

Ms. Jeanne Palmer

Ms. Sally Robinson

Ms. Susan Speth-Briganti

Dr. Wei Yang

Mr. Bill Welch

Ms. Rosemary West

Dr. Carol White

Ms. Laura Hale, Grants Analyst

The Center for Health Improvement, Social Entrepreneurs, Inc, and Demetras Consulting Services provided organization, management, data collection tools, analysis, facilitation and report writing for this project.

CHI can be contacted at 1330 21st Street, Suite 100, Sacramento, California 95814 (916) 930-9200 Web address: www.centerforhealthimprovement.org

SEI can be contacted at 6121 Lakeside Drive, Suite #160, Reno, Nevada 89511 (775) 324-4567, or on the Internet at http://www.socialent.com

Demetras Consulting Services can be contacted care of Social Entrepreneurs, Inc., at (775) 843-9756 or via email at Kari.Demetras@sbcglobal.net

Table of Contents

1. HISTORY: THE FUND FOR A HEALTHY NEVADA

The Fund for A Healthy Nevada was created in accordance with NRS 439.620 – 439.630 to utilize 50% of tobacco settlement monies received or recovered, by the state of Nevada. The life expectancy for the Fund is through the year 2025.

The Task Force for the Fund for a Healthy Nevada was established to be the decision making body for these funds. The Task Force is comprised of members who are appointed by the majority leader of the senate, the speaker of the assembly, or by the governor, in accordance with NRS 439.625. Membership includes two legislators and up to seven members of the public. (See page i for list of members through 2003)

The Task Force, by its original statute was mandated to allocate not more than 20% "for programs that prevent, reduce or treat the use of tobacco and the consequences of the use of tobacco;" and not more than 20% "for programs that improve health services for children and the health and well-being of disability services." The passage of Assembly Bill 504 amended NRS 439.630 to split the 20% allocation for children's health and disabilities, with 10% going for children's health, 7.5% going for disability services, and 2.5% going for prescriptions for disabled persons, beginning in July, 2004. The remaining funds are divided with 30% for the Senior Rx program, and 30% to assist senior citizens with independent living.

The duties of the Task Force include:

- Conducting public meetings to gain public testimony regarding programs of relevance to the Fund;
- Establishing a process to evaluate and rank the health and health needs of residents of the state;
- Allocating portions of the Fund for a variety of programs as described by statute and;
- Developing policies and procedures for the administration and annual distribution of grants through competitive requests for proposals.

The Task Force is also charged with ensuring that any money expended from the Fund will not be used to supplant existing methods of funding.

Staff members from the Legislative Counsel Bureau provide direct support to the Task Force on statutory interpretation, agenda development, meeting coordination, and tracking of actual available funds from the tobacco settlement agreement. Staff from the Department of Human Resources, Director's Office, solicit applications and administer grants under the allocations identified above for tobacco control and treatment, children's health, and disability services.

Grants are awarded on a biennial basis. The first awards were made in state fiscal year 2001 with most continuing into fiscal year 2002. The second cycle of awards began in state fiscal year 2003, with most running through 2004. The next award cycle will be July 1, 2004 through June 30, 2006. Funding to date has addressed the following areas:

- Tobacco Control
- Services to Disabled Persons
- Respite and Independent Living
- Oral Health
- Chronic Diseases
- Access to Health Care
- Family Planning
- Immunizations
- Injury and Violence Prevention
- Maternal, Infant & Child Health
- Fitness and Nutrition
- Substance Abuse

Throughout 2002-2003, the Task Force worked to establish priority areas and goals related to the grant allocations under the Fund. Uniform Measures included in this evaluation plan will be the mechanism used in future evaluation efforts to identify and document progress toward achieving goals within the established priority areas.

2. EVALUATION PLAN INTRODUCTION

In order to demonstrate accountability, assess program implementation and outcomes, and increase program efficiency and impact, in 2002, the Task Force allocated a small percentage of Task Force funds for program evaluation of the grants to improve healthcare for children and disability services. Part of the funds were set aside to develop this five-year evaluation plan.

The Center for Health Improvement (CHI) was awarded the contract to develop the plan in January 2003. CHI, in partnership with Social Entrepreneurs, Inc. (SEI) and Kari Demetras of Demetras Consulting Services began work on the evaluation in February 2003. The approach used by the Team was a research-based evaluation framework derived, in part, from the Results-Based Accountability Model developed by the Fiscal Policy Studies Institute. This framework was utilized because it allows for ongoing flexibility and sustainability of the evaluation plan by establishing a model that can be used in future years to determine new accountability measures and evaluate new goals as priorities within the state change.

A statewide evaluation team was established that included Grantees representing different program areas, as well as Task Force members, and Department staff. The evaluation plan includes Uniform evaluation measures that were developed in conjunction with the Statewide Evaluation Team to establish specific strategic results desired by the state with information on performance clustered by both *category of service* and *geographic region*. Three geographic breakouts are included: Washoe County, Clark County and the balance of the state. This evaluation plan includes specific outcomes identified by funded programs' *category of service,* e.g. children's health or disability services.

In understanding the development of the evaluation plan and the use of Results-Based Accountability (RBA), it is helpful to understand several principles from RBA that governed the development of the plan.

- The plan must be **credible**. Policy makers and citizens must have confidence that the information produced is accurate and relevant. Performance measures must be credible representations of the quantity and quality of the services provided.

- The evaluation plan must be **fair.** The plan must create a system that provides fair gauges of agency and program performance. This means that measures should generally reflect factors and products that agency and program managers can influence or control by focusing on bottom-line quality. Fairness is as much a matter of how data are used as how they are selected. Performance measurement should be used as a tool to improve performance.

- The evaluation should include Uniform Measures that are **clear** and easy to understand and use. If measures are too complicated, they will be of little use in helping decision makers and the public understand performance or point out where improvements are needed.

- The evaluation plan should be **practical** to administer and implement. The way in which data are collected is a major factor in practicality. One dimension of practicality involves the development, operation, and linkage of data systems. Different agencies often collect information on the same people. While difficult, it makes sense for the evaluation to coordinate and link data collection strategies and instruments.

- As public goals and policies change, the evaluation plan must **adapt** to reflect these changes. When priorities and funded programs change, data requirements must change as well, and the evaluation needs to keep pace with these changes.

- Finally, the evaluation plan must be **connected** to and integrated with other aspects of public planning, budgeting, and management systems. Uniform Measures are designed to provide feedback about the effectiveness of agencies, programs and policies.

The plan uses the Results-Based Accountability Model's four-quadrant approach to evaluation as described in the following table. Results-Based Accountability addresses the fact that not all of the evaluation questions in this table are equally important. The evaluation plan is designed to focus on quality as well as quantity. In addition to *counting effort,* the plan also *measures effect*.

	QUANTITY	QUALITY
EFFORT	**Q1** What did we do? How much service did we deliver?	**Q2** How well did we do it? How well did we deliver service?
EFFECT	**Q3** Is anyone better off (#)? How much change for the better did we produce?	**Q4** Is anyone better off (%)? What quality of change for the better did we produce?

In each quadrant the questions are answered with # or % data statements:

- ☐ What did we do? (e.g. # of clients served, # of activities performed)
- ☐ How well did we do it? (e.g. % of timely actions, % complete actions, client staff ratios, unit cost)
- ☐ Is anyone better off? (# and % of clients who show improvements in skills/knowledge, attitude, behavior or circumstance)

Using this model the plan has been designed to evaluate four types of outcomes statewide as well as by category of service and geographic area. This includes evaluating: 1) **services**, 2) **success factors,** 3) **program results, and** 4) **sustainability**. Some of the Uniform Measures established in this plan focus upon the evaluation of services while others speak to program results. The success factors and sustainability evaluation will be derived from an analysis of a combination of qualitative and quantitative data, collected during the course of the evaluation.

Glossary

The following terms are germane to the evaluation and used throughout this plan:

- Cluster calls: a facilitated learning experience that groups participants by area of interest or need to engage in dialogue around specific topics.
- Likert Scale: a tool used to assess a set of attitude statements. Subjects are asked to express agreement or disagreement on a five-point scale. Each degree of agreement is given a numerical value from one to five. Thus, a total numerical value can be calculated from all the responses.
- **Primary Health Provider: as defined by Healthy People 2010, a primary health provider is a source of continuity for all health needs, providing comprehensive assessment and referrals to specialists.**
- Priority Areas: the two areas of funded programs that are priorities for the Task Force, based on the requirements of the statute. The priority areas are children's health and disability services.
- Results based accountability: a model of performance measurement introduced by the Fiscal Policy Institute to measure and report on results from funding.
- SET: Statewide Evaluation Team that provided feedback and guidance during the development of the Uniform Measures.
- Uniform Measures: measures which tell how well a program, agency or service system is working in achieving the desired results.
- Vigorous exercise: as defined by Healthy People 2010, v**igorous physical activity is rhythmic, repetitive physical activity that uses large muscle groups at 60% or more of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute, minus age.**

3. EVALUATION PLAN

The plan to evaluate the Fund for a Healthy Nevada is comprised of three key elements, 1) the training and technical assistance necessary to orient Grantees to the process and assist them in implementing the tools, 2) the tools used throughout the process and 3) the timeline and milestones to implement the evaluation processes. Each of these elements is described in this chapter. The elements described are specific to the first year of the five-year evaluation plan. It is expected that these elements will be reviewed and revised over the course of the five years, based upon feedback and results.

The evaluation will utilize a variety of data collection instruments to compile both qualitative and quantitative data. A variety of methods will be used to evaluate the Fund for a Healthy Nevada. Each method has multiple purposes in the evaluation. Methods will be evaluated and revised over time as the capacity of Grantees and the availability of data is strengthened. Data collected by the grantees will be coordinated to sort the evaluation data in a variety of manners. This will help portray the unique Fund for a Healthy Nevada outcomes by geography, category of service or both at the local, regional and state level.

Recognizing the multiple demands on Grantees, the data collection instruments will be simple in design, collecting only the information that will be used in reports. Grantees will enter data directly into the various data collection instruments and submit reports quarterly and annually. The data will be compiled and analyzed for development of an annual report of the Fund for a Healthy Nevada.

All tools used in training and technical assistance or for reports during the evaluation will be posted on the Fund for a Healthy Nevada website. In addition, training guides and "how to" manuals will be compiled to instruct current and future Grantees in the use of the evaluation tools.

Training and Technical Assistance

Training and technical assistance will be available to all Grantees to assist them in selecting Uniform Measures and the tools that will best serve them in reporting on progress toward achieving those Uniform Measures. Training and Technical Assistance will be provided in a variety of ways to ensure the successful implementation of the evaluation tools and processes. Training events will be customized for a variety of key stakeholder groups and these groups will participate with peers in the training opportunities. Materials will be developed that provide tangible examples using the Fund for a Healthy Nevada Grantees.

There are multiple ways in which Grantees will have access to training and technical assistance, as well as ways in which training and technical assistance needs will be identified and addressed. In the first year of the five-year evaluation plan, a series of initial training and technical assistance events will take place. In addition, throughout the five-year implementation of the evaluation plan, ongoing training and technical assistance events will also occur. Specific activities, broken out by one-time events and activities occurring during the first year, and ongoing activities which will continue beyond the first year, are described on the next two pages.

One-time Activities:

Regional workshop: A two-day training workshop will be used to introduce Grantees to Results-Based Accountability, including the four quadrants of evaluation data and the Uniform Measures selected for children's health and disability services. This regional workshop will take place in both northern and southern Nevada.

Targeted Technical Assistance (TA): Targeted TA will be provided to assist Grantees in identifying appropriate/ useful Uniform Measures for their organizations, selection of evaluation tools that best capture information related to the measures, and on implementation of the tools. A variety of activities will be available to Grantees, including:

- Organizational Assessment Tool: The Evaluators will develop an assessment tool for Grantees to assess their individual strengths and needs based upon size, budget, evaluation experience, complexity of services and existing infrastructure. Grantees will submit their assessment to the Evaluators in order to schedule a Technical Assistance (TA) site visit.

- On Site Technical Assistance: Each Grantee will be offered a TA visit with the Evaluators and the Fund for a Healthy Nevada Grant Administrative Staff to provide guidance in selecting and implementing Uniform Measures specific to their individual program. The TA visit will be scheduled by the Grantee at a convenient time based on their own readiness to begin implementing the new evaluation tools. A set number of TA visits will be available from September 2003 to March 2004 on a first come, first serve basis.

Ongoing Activities:

Web site: A bulletin board for peer to peer sharing will be used to connect Grantees with each other as resources and support. In addition, the website will have a resources section that will identify other resources of interest and grants available for Grantees. It will include minutes and meeting notices that may assist Grantees with evaluation. An electronic bulletin board will also be available for individual and group consultation.

Cluster Calls: Approximately seven cluster calls will be used to create a peer learning environment while identifying lessons learned and best practices used by Grantees. The Evaluators will facilitate the calls with the results documented as success factors, sustainability or both. Cluster calls with content experts and resources will be used to provide additional information for groups of Grantees working on a particular element of the evaluation plan. Cluster calls will allow Grantees to share information and leverage learning by sorting participants by topic area, services provided, Uniform Measures to be reported or geographic area.

Cluster calls will include participants list, agenda and minutes to document participation and lessons learned. Cluster calls may be organized by category of service, geographic area or by like-minded issues. Cluster calls will not exceed 90 minutes in length and will only be used for interactive, discussion based evaluation activities, rather than to collect static data or progress information. Cluster calls will conclude with an evaluation to highlight success and improve future calls. All participants will be asked to summarize key learning at the

conclusion of each call. One cluster call will take place with newly funded Grantees in May 2004 to orient them to the evaluation plan and the process for accessing training and technical assistance including how to participate in future cluster calls.

One-on-one learning opportunities: Individualized learning opportunities, customized to each Grantee's unique needs will be provided via peer mentoring from other Grantees, targeted follow up and phone consultation with the Evaluators.

Evaluation Tools

A variety of evaluation tools will be designed to assist Grantees in capturing meaningful information about their program's services, successes and challenges. These tools will be piloted with a diverse group of Grantees prior to being rolled out to all Grantees. Beta tests will identify ease of use for the end user, functionality, likelihood of user error, and value of the tool. Worksheets that can be downloaded and completed online will be developed where possible. Development of tools will consider the time, cost, resources and equipment needed to utilize the tool. Tools will also be developed with feedback from those who will use the tools, to assess each tool's clarity and ease of use. Manual input forms will also be used that can be mailed to team members for input into the system.

Grantees will receive assistance from the evaluators in selecting the tool(s) that will best support them in collecting meaningful information for the particular Uniform Measure(s) they have selected. Grantees will not be required to use the tools developed or may customize the tools to best meet their individual needs. Evaluation tools will include:

Surveys: Surveys will be used to identify success factors, assess sustainability, measure client satisfaction and capture specific information related to category of service or unique circumstances experienced geographically. Surveys will be developed in electronic form where possible, to avoid the cost of issuing and collecting information via hard copy. When a scale is used on surveys, a measure will be employed to avoid responses that congregate at the mean. Web-based survey sites will be used to issue surveys to Grantees. Client surveys will be developed for literate and non-literate clients as well as English speaking and non-English speaking clients. Quality translations will be used for non-English speaking versions of the surveys. Specific surveys to be developed include:

- a client stakeholder satisfaction template,
- a success and sustainability survey, and
- an organizational self-assessment survey.

Worksheets: Customized worksheets will be used by Grantees to document progress toward grant outcomes and Uniform Measures. Worksheets will also be used to report basic demographic information by categories of service. Worksheets will be used to identify quality and cost associated with various programs by categories of service. Worksheets will be designed with input provided at the Regional Workshops from stakeholders who will

play a variety of roles in data collection. Specific information will be solicited from administration, finance and service provider representatives. Worksheets to be developed include:

- Client Profile Worksheet
- Service Delivery Worksheet
- Cost Benefit Worksheet

Reports: Three types of reports will be developed through the implementation of the evaluation plan including 1) Grantee reports, 2) Evaluator reports, and 3) an Annual report issued by the Task Force for the Fund for a Healthy Nevada.

- Grantee reports: Reporting is an ongoing requirement for the Fund for a Healthy Nevada Grantees. Reports to be generated by Grantees include Quarterly Reports and an Annual Report.
    - Quarterly Reports: Grantees will submit quarterly reports for funded programs that report on services, finances, and results. Data reported quarterly will include program utilization and outcomes information, client demographics, program costs and other Uniform Measures selected by the Grantee. Quarterly Reports will be due three times in each twelve-month period, by the last day of the month that follows the end of the period.
    - Annual Report: Grantees will submit an annual report that includes fourth quarter data as well as cumulative data collected over the course of the twelve months. The annual report will include a narrative description of progress, obstacles, program design changes and success factors. The report will also indicate any projected expenditure of funds through year-end, and any carry over of funds requested. This report will solicit the Grantee's own evaluation of their program and be based upon a revised version of the current annual report format used by the Fund for a Healthy Nevada.
- Evaluator reports: A number of interim reports will be developed in the course of implementing the evaluation plan. These reports include summary reports from Cluster Calls and a summary report at the conclusion of initial Grantee on site technical assistance visits.
- Task Force Report Card: The Task Force for the Fund for a Healthy Nevada will be responsible for overseeing the synthesis of all reports into an Annual Report Card for the Fund for a Healthy Nevada, using Uniform Measures, Healthy People 2010 Nevada data elements, and data elements from the State of Nevada Strategic Plan on Disabilities. This Annual Report Card will be published each September in cooperation with Dr. Wei Yang, Center for Health Data and Research. Quarterly grant reports, reports to other funders, the needs assessment for the Fund for a Healthy Nevada statewide evaluations, and plans that impact these priority areas will be reviewed and compared to data collected from Grantees. The Report Card will show baseline rates and identify targets for each of the elements reported on. Over time, it will be updated to measure progress toward achieving goals in the priority

areas. When available, data will be sorted by geographic area or category of services and linked to the Uniform Measures. Reporting tools to be developed include:

- Quarterly Report Form
- Annual Report Template
- Report Card Template
- Evaluator Summaries

Evaluation Timing and Milestones

The evaluation plan covers a five-year period. A series of milestones have been identified that indicate the progression of the evaluation throughout implementation. Milestones are sorted into one of two tables based upon whether they are part of the initial implementation of the evaluation plan, or they are ongoing activities. A summary of the major milestones and timing by year is provided in the following charts.

Initial Implementation Activities

Evaluation will be implemented for fiscal year 03-04 using a phased approach. Prior to implementation, each element of the evaluation will be piloted with a set of Grantees and beta tested to ensure its functionality.

Grantees will begin using the Uniform Measures and new reporting tools on a voluntary basis in October 2003. Additional Grantees will be phased in each quarter with all Grantees selecting final Uniform Measures by June 2004. All evaluation tools will be implemented by July 1, 2004.

Ongoing Activities

Once the Uniform Measures are implemented, Grantees will be responsible for three quarterly reports and an annual report that includes fourth quarter and cumulative data for the twelve-month period. Quarterly Reports will be due by the final day of the month following the close of the quarter. Annual reports will be due by July 31 each year.

Quarterly and annual reports will be used along with other data sets, to create and then update the Fund for a Healthy Nevada Report Card which will be published each September. Periodic review and revision to the Uniform Measures will occur during the course of the five-year evaluation plan, to ensure that the most appropriate and actionable Uniform Measures are used to set goals and measure performance by Grantees.

INITIAL EVALUATION MILESTONES

INITIAL IMPLEMENTATION ACTIVITY	TIMING
Regional Workshop with Grantees to introduce evaluation plan Uniform Measures and timeline	August 2003
Fund for a Healthy Nevada Evaluation website goes live	September 2003
Cluster Call by Geographic region	September 2003 to November 2003
Technical Assistance and On Site Technical Assistance Visits with Grantees	September 2003 to March 2004
Evaluation forms and tools posted on website	October 2003
Phase 1 implementation of quarterly evaluation processes by volunteer Grantees	October 1, 2003
Cluster Call by Topic	November 2003 to December 2003
Fund for a Healthy Nevada RFA posted on website	December 2003
Phase 2 implementation of quarterly evaluation processes by volunteer Grantees	January 1, 2004
Cluster Call by Topic	January 2004 to February 2004
Phase 3 implementation of quarterly evaluation processes by remaining Grantees	April 1, 2004
Cluster Call with new Grantees	May 2004
Grantee Annual Report due	August 15, 2004

ONGOING EVALUATION MILESTONES

ACTIVITY	TIMING
Grantees select and finalize Uniform Measures for new grant period	June 2004
First Annual Fund for a Healthy Nevada Report Card published	September 2004
Quarterly Report Due	October 31, 2004
Quarterly Report Due	January 31, 2005
Quarterly Report Due	April 30, 2005
Grantees finalize Uniform Measures for next four quarters	June 2005
Grantee Annual Report Due	August 15, 2005
Annual Fund for a Healthy Nevada Report Card Published	September 2005

ACTIVITY	TIMING
Interim evaluation of Uniform Measures	October 2005
Quarterly Report Due	October 31, 2005
Quarterly Report Due	January 31, 2006
Quarterly Report Due	April 30, 2006
Grantees finalize Uniform Measures for next four quarters	June 2006
Grantee Annual Report Due	August 15, 2006
Annual Fund for a Healthy Nevada Report Card Published	September 2006
Quarterly Report Due	October 31, 2006
Quarterly Report Due	January 31, 2007
Quarterly Report Due	April 30, 2007
Evaluation and Revision of Uniform Measures	May 2007
Grantees finalize Uniform Measures for next four quarters	June 2007
Grantee Annual Report Due	August 15, 2007
Annual Fund for a Healthy Nevada Report Card Published	September 2007
Quarterly Report Due	October 31, 2007
Quarterly Report Due	January 31, 2008
Quarterly Report Due	April 30, 2008
Grantee Annual Report Due	August 15, 2008
Annual Fund for a Healthy Nevada Report Card Published	September 2008

Summary

A variety of tools and processes will be used during the five-year period covering the evaluation. Timelines and activities will be reviewed and revised during the five years to ensure an efficient and effective process. The tools developed will be used to assist Grantees in reporting on their program services and activities. Once Uniform Measures are selected by Grantees, the tools they elect to use to report on their progress toward improving Uniform Measures are optional. Grantees will report on Uniform Measures quarterly and with an annual report that includes fourth quarter and cumulative data for the twelve-month period.

The Task Force will publish an Annual Report Card that will include information from Grantees as well as from other sources that describe the status of children's health and disability services in Nevada, with select descriptors that speak to these two priority areas.

4. QUESTIONS TO MEASURE RESULTS

The evaluation plan tools and methods described in Chapter 3 are designed to address four key result areas. They include an evaluation of:

- Services
- Results
- Success factors
- Sustainability

In order to evaluate the four key result areas, questions were developed that will be answered via the data collection process and tools described in Chapter 3. While a number of questions are of interest and important as related to children's health and person's with disabilities in Nevada, the Evaluators and the Statewide Evaluation Team (SET) worked together to identify the most crucial questions to be answered in the course of the evaluation. After a review and additions by the SET, the following questions were suggested for use on the evaluation tools. Some of the questions will provide the content for quarterly and annual reports to be submitted by Grantees during the evaluation. Others will be summarized in the Evaluator summaries or the Annual Report Card.

Program Evaluation Questions

Evaluation of Services and Activities

- Who are the customers, clients, people served by Task Force grants?
- What are the demographics of clients receiving services or who is impacted by Grantee activities?
- What services and activities are being provided with Task Force funding?
- How are Grantee activities conducted or services provided?
- What is the cost of services in relation to the ability of a person/family to pay for services; including services covered at some level by insurance?
- Did the Task Force Grantees meet their contracted service or activity goals, performance, and outcome measures?
- How effective and efficient were the Task Force Grantees in providing the type and quantity of contracted services or activities?
- Were Task Force clients satisfied with the services provided by Grantees?

Evaluation of Success Factors

- What are some of the lessons learned by the funded programs when comparing strategies, outcomes and costs?

- How can the system of collecting results and performance data be improved for future evaluations and contracts?

- What synergistic strategies have impacted timeliness, affordability and access of services?

- To what extent have programs funded by the Task Force built upon existing resources and promising practices?

Evaluation of Results

- What impact did the Task Force Grants have on specific Uniform Measures and data elements of the Healthy People 2010 Nevada Report and the State of Nevada Disabilities Strategic Plan?

- What systemic or policy changes have come about as a result of programs funded by the Task Force?

- What is the baseline data to measure the next funding awarded based upon the Uniform Measures indicated in the evaluation plan?

- Are there any data that need to be collected to fill gaps in baseline data?

- What system for collecting the necessary missing baseline data is recommended?

Evaluation of Sustainability

- What strategy will be implemented to do a longitudinal study to evaluate the impact of the programs funded by the Task Force over time?

- How will the Task Force evaluation system assess the overall impact of the programs in achieving progress toward Healthy People 2010 indicators as applicable to this program and other priorities as identified by the Task Force over time?

- What can the Task Force or State do to assist Grantees in being successful?

- What additional funding sources, systemic changes such as community support or in-kind donations or other resources have been developed as a result of the Task Force Funding?

- What innovations related to new stakeholders or new models have resulted from Grantee activities?

5. DEVELOPING UNIFORM MEASURES

The Uniform Measures for children's health (Chapter 6) and disability services (Chapter 7) were developed in conjunction with the SET during three facilitated meetings. The first meeting, held March 14, 2003 in Reno, provided an in-depth training on Results Based Accountability (RBA). The training explained the RBA approach to evaluation and how that process would be used to develop Uniform Measures for the Statewide Evaluation Plan. During this meeting, Uniform Measures were defined as those ***measures which tell how well a program, agency or service system is working in achieving the desired results***. The next two meetings of the SET focused entirely on developing and refining Uniform Measures for children's health and disabilities. These meetings were conducted via videoconference from the Department of Transportation offices in Carson City and Las Vegas on April 17, 2003 and May 22, 2003. This Chapter describes those meetings and the processes used to develop the Uniform Measures contained in the next two chapters.

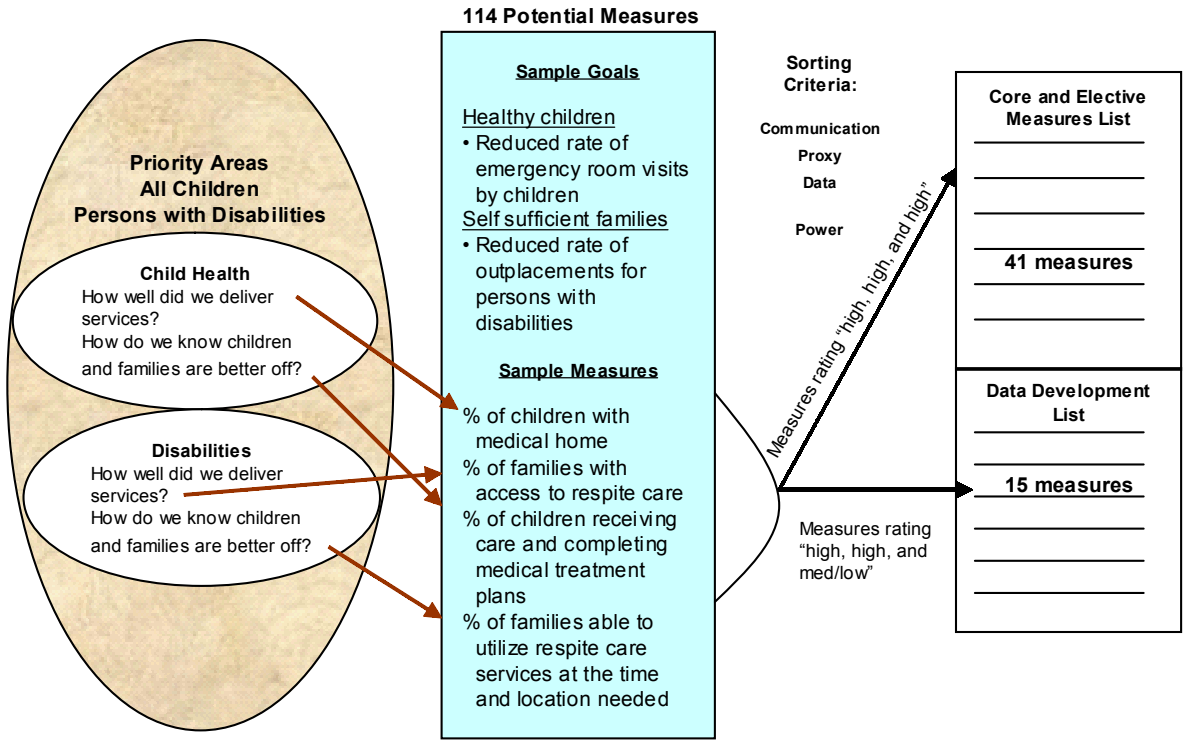
The first step in developing Uniform Measures was to review each of the programs currently being funded by the Fund for a Healthy Nevada in order to identify and list those measures presently being tracked. Added to this list were child health and disability measures tracked through Healthy Nevada 2010 and the State Disability Strategic Plan. Finally, independent research was performed to identify other child health and/or disability measures tracked in other initiatives at the state, regional or national levels. This resulted in a "laundry" list of 114 potential Uniform Measures (70 child health measures and 44 disability measures).

The next step was for the SET members to review, refine, and prioritize the list of potential measures during the April videoconference. Working in small groups, the SET evaluated and rated each potential measure as high, medium or low in three areas:

- Communication Power – does the measure communicate to a broad range of audiences?
- Proxy Power – does the measure say something of central importance about the goal and does it bring along other data elements?
- Data Power – does the measure have quality data available on a regular basis (at least quarterly)?

At the conclusion of the April meeting, the SET had refined the list to 41 measures that were considered high in communication, proxy and data power. Fifteen other measures that were considered high in communication and proxy power, but either low or medium in data power, were placed on a data development list. The graphic on the next page illustrates the process used for this first step. All tools and processes are documented and replicable for use in updating the evaluation plan in the future.

Creating a Core List of Uniform Measures
Process Flow Chart



The shorter, refined list of measures was then organized according to the priority areas and draft goals submitted by Task Force members. The measures which had been rated "high" for all three types of communication power yet did not fit a specific goal of the priority areas were noted and labeled elective measures. These Uniform Measures reflected current funding areas and/or nationally recognized children's health or disabilities measures fitting these areas.

The next step in drafting the Uniform Measures occurred during the May meeting when the SET members were tasked with further evaluation of the potential measures to ensure selection of the best measures for the draft goals. To do this, the SET used the Results-Based Accountability Model's four-quadrant approach to evaluation described in Chapter 2.

Each proposed measure was scrutinized, and where necessary revised, to reflect an improvement in the overall condition or well-being of the target population or in the quality of services delivered; moving away from measures which only counted numbers of individuals served or units of service delivered. At the conclusion of that meeting the SET members had developed a final set of core Uniform Measures for children's health, disabilities, recommended "elective" measures, and a list of data development measures (measures high in

communication and proxy power, but for which reliable data is not available currently on a regular basis) that became the data development agenda for the future.

The next two chapters document the Uniform Measures developed for children's health and disability services. The data development list is presented in Chapter 8, Recommendations for Ongoing Evaluation.

6. CHILDREN'S HEALTH: UNIFORM MEASURES AND RESULTS TO ACHIEVE

The Uniform Measures developed for children's health are organized into three groups: 1) measures that apply to Task Force goals for Children's Oral Health; 2) measures that apply to Task Force goals for Overall Children's Health, including chronic disease; and 3) Elective Measures – those measures that apply to the priority areas but not to a specific goal. All measures presented here were developed using the process outlined in Chapter 3, and were rated "high" in communication, proxy and data power.

Children's Oral Health

There are two goals for Children's Oral Health.

Goals and Uniform Measures

Goal 1: Provide all children with access to timely and affordable dental care, including prevention, education and restorative treatments, in urban and rural Nevada.

a. Percent of families (working or not) who attest to improvement in access to care as a result of enabling policies and/or services [provider, employer, education level].

b. Percent of children with untreated dental caries.

c. Length of waiting time to access services.

d. Percent of children who have dental sealants by age eight.

e. Percent of children diagnosed with oral health conditions that have access to appropriate dental care, including education, prevention and treatment.

f. Percent of consumers reporting satisfaction with the oral health services and assistance they receive.

Goal 2: Early detection of oral health disease.

a. Percent of children diagnosed with oral health disease that have access to appropriate dental care, including education, prevention and treatment.

b. Percent of consumers reporting satisfaction with the oral health services and assistance they receive.

Children's Overall Health Core Uniform Measures

There are five goals related to children's overall health.

Goals and Uniform Measures:

Goal 1: Improve access to and utilization of comprehensive health services [physical/mental].

a. Percent of previously uninsured children who obtain some form of health insurance (Medicaid, private insurance, Nevada Check-Up).

b. Percent of children who receive appropriate health care services as a result of screenings and/or other supportive services.

c. Percent of children [with health coverage] who had at least one visit with a primary health provider in the past year.

Goal 2: Reduce the incidence, prevalence and resulting complications of chronic disease among children in Nevada.

a. Percentage of children engaged in healthy behaviors such as vigorous physical activity regularly or nutrition programs (e.g. 3 times per week).

b. Percentage of children with obesity.

c. Percentage of children with a treatment plan implemented that reduces complications of present chronic disease.

Goal 3: Decrease the percentage of children and youth whose basic needs are not being met.

a. Percentage of children with skipped meals or hunger due to lack of food (food insecurity).

b. Percentage of children living at or below the poverty level.

c. Percentage of children experiencing hunger who regularly utilize nutrition programs.

d. Percentage of families with children living in temporary shelters and/or housing.

Goal 4: Reduce substance use and/or abuse (alcohol, tobacco, and other drugs) among youth.

a. Percent of youth using tobacco, alcohol and other drugs in the last thirty days for one or more days.

Goal 5: Reduce prevalence of preventable injuries and death among young children by 50%.

a. The rate of preventable maltreatment, injuries, and death among children or youth related to causes such as: motor vehicles, suicide attempts, guns, violence, or child abuse/neglect.

Elective Uniform Measures

a. Infant mortality rate.

b. Percent of children living at or below the poverty level.

c. Percent of women who enroll in prenatal care in the first trimester, as measured by when care started, frequency of care, and how long they participated.

d. Percent of infants born with healthy birth weights.

e. Percent of children with up-to-date immunizations at age 2 and at Kindergarten entry.

f. Percent of program staff who offer culturally and linguistically appropriate services to the underserved.

g. Number of agencies that have consumers involved in program design.

h. Percentage of women who are screened during prenatal care visits and receive appropriate services for smoking, alcohol use, domestic abuse and illegal drug use.

i. Percent of change in length of time from application for services to receipt of services.

j. Percent of children and adolescents completing treatment plans by specific type of service.

k. Percent of consumers with changed behaviors or knowledge as a result of treatment and/or service encounters.

l. Rate of married/unmarried adolescent pregnancy by age groups 12-14, 15-17, and 18-19.

7. DISABILITY SERVICES: UNIFORM MEASURES AND RESULTS TO ACHIEVE

Uniform Measures for disability services were developed using the process outlined in Chapter 3, and reflect the measures contained in the State Disabilities Strategic Plan. The Uniform Measures developed for disability services are organized into two groups: 1) Core Uniform Measures related to specific Task Force goals for Disability Services; and 2) Elective Uniform Measures – those measures that apply to the priority area but not to a specific goal. All measures presented were rated "high" in communication, proxy and data power. Progress toward improving disability services was made during the 2003 Legislative session. AB 504 was passed which requires the Director of the Department of Human Resources to apply to the Federal Government for a Medicaid waiver, after a determination is made that sufficient funding is available to implement the waiver, to extend coverage of prescription drugs and other related services to persons with disabilities who have been determined to be eligible for disability benefits for the federal social security system.

Disability Services Core Uniform Measures

Goal 1: Develop "no wrong door" service delivery network within 5 years.

a. Number and types of disabilities services that are culturally and linguistically appropriate.

b. Percent of families (working or not) who attest to improvement in access to care as a result of policies and/or services [provider, employer, education level].

c. Percent of individuals with speech/language/developmental delays receiving integrated services. (also applies to Goal 3)

d. Percent of individuals with disabilities who receive appropriate health care services as a result of screening, early diagnosis, treatment and disease monitoring.

e. Percent of individuals with disabilities who receive appropriate supportive services as a result of screenings.

Goal 2: Reduce the incidence, prevalence and resulting complications of chronic disease in Nevada.

a. Percentage of persons engaged in healthy behaviors such as vigorous physical activity regularly (e.g. 3 times per week).

b. Percentage of persons with a treatment plan implemented that reduces complications of present chronic disease.

Goal 3: Nevada family caregivers will have at least one formal respite care option.

a. Number of hours of respite services or caregiver visits provided per consumer per year to families with disabilities.

b. Percent of family caregivers reporting insufficient respite options.

Goal 4: Individuals with disabilities will be able to maintain independence to the extent possible.

a. Percentage of individuals and/or families of those with disabilities utilizing peer support, training, and/or other community support services.

b. Percent of individuals with developmental delays and other special needs that have access to quality care in natural environments.

c. Percent of disabled individuals able to maintain non-institutional living as a result of supportive services (e.g., respite care, assistive technology, and supportive living arrangements).

d. Percent of individuals reporting satisfaction with the services and assistance they receive in pursuing their goals.

Elective Uniform Measures

a. Percent of disabled persons living at or below the poverty level.

b. Percent of program staff that provide culturally and linguistically appropriate services to the underserved.

c. Number of agencies that have consumers involved in program design.

d. Percentage of women who are screened during prenatal care visits and receive appropriate services related to preventing disabilities.

e. Percent of change in length of time from application for, to receipt of, services.

f. Percent of persons with disabilities completing treatment plans by specific type of service.

g. Percent of persons with disabilities indicating an increase in their quality of life as a result of services.

h. Percent of consumers with changed behaviors or knowledge as a result of treatment and/or service encounters.

8. RECOMMENDATIONS FOR ONGOING EVALUATION

It is essential that recommendations for investments in new and better data are an active part of the evaluation plan work. RBA suggests that defining the data development agenda or those Task Force priorities for securing data related to the Uniform Measures is critical.

Spending for data or any other administrative function should be carefully balanced with spending which directly benefits children and disability services and their families. The Fiscal Policy Institute suggests that efforts to obtain baseline data on Uniform Measures should not exceed 5 to 10% of a budget. Moreover, data investments are only part of that amount. Often other partners or service providers themselves will have to contribute to this effort.

Another principle of the data development agenda promoted by RBA is that not all data has to be of the highest research quality. As preliminary stages of learning regarding the use of Uniform Measure results in making funding and grant award decisions, sampling and other techniques to get usable information that may not meet strict academic research standards is considered acceptable.

The measures below form the recommended data development list which evolved from the process used to develop the Uniform Measures. Each measure was identified as "high" in communication power (speaks to a wide audience) and proxy power (says something of central importance about the goal/priority area), but was either medium or low in data power (consistent data available on at least a quarterly basis).

- ☐ Number of parents who attend nutrition education classes.
- ☐ Number of providers, defined by category and subcategory of care, serving children, especially in under-served populations; and the volume and/or level of services provided.
- ☐ Percentage of parents that adopt healthier meal choices.
- ☐ Percent of pregnant women referred to a smoking intervention that report long-term tobacco cessation postpartum.
- ☐ Percent of children with skipped meals or hunger due to lack of food.
- ☐ Violent crime offending rate for adolescents.
- ☐ Percent of smoking, alcohol, and drug-exposed births.
- ☐ Percent of youth with HIV/AIDS within specific populations.
- ☐ Number of reports/incidents of caregiver abuse or neglect.
- ☐ Percent of disabled individuals that live and participate in their community.
- ☐ Percent of disabled individuals that have economic security.

APPENDIX A: ANNUAL REPORT AND REPORT CARD

The Task Force for the Fund for a Healthy Nevada will issue an Annual Report Card on the status of children's health and disability services in Nevada. The report card will indicate the baseline, goal and current trends for a number of measures and data elements that when combined answer the question of how children's health and disability services are improving in Nevada. The Task Force for the Fund for a Healthy Nevada will be responsible for overseeing the synthesis of data received from statewide reports, federal sources, Grantees' quarterly and annual reports, and community needs assessments and for publishing of the Annual Report Card. A template for the report card is provided below:

Report Card Template

200[X] Nevada's Report Card for Children's Health and Disability Services

Each year issued, insert introductory paragraph summarizing background leading to development of the report card, its purpose, and the number of organizations participating. Include an overview of the number and types of Grantees involved in addressing goals and improving trends, etc. Note that quarterly and annual Grantee reports will be used along with a variety of other data sources to identify changes in key measures and data elements.

Explain highlights of findings (trends) shown on the report card, and where persons can find additional and/or more detailed information about data sets for ethnicity, age, geography, etc.

Summary of The Fund for a Healthy Nevada Report Card Goals

Children's Oral Health

- Provide all children with access to timely and affordable dental care, including prevention, education and restorative treatments, in urban and rural Nevada.
- Early detection of oral health disease.

Children's Overall Health

- Improve access to and utilization of comprehensive health services [physical/mental].
- Reduce the incidence, prevalence, and resulting complications of chronic disease among children in Nevada.
- Decrease the percentage of children and youth whose basic needs are not being met.
- Reduce substance use and/or abuse (alcohol, tobacco, and other drugs) among youth.
- Reduce prevalence of preventable injuries and death among young children by 50%.

Disabilities Services

- Develop “no wrong door” service delivery network within 5 years.
- Nevada family caregivers will have at least one formal respite care option.
- Reduce the incidence, prevalence and resulting complications of chronic disease in Nevada.
- Individuals with disabilities will be able to maintain independence to the extent possible.

[2003] Nevada's Report Card on Children's Health and Disability Services

Children's Oral Health	Current Year	Benchmark Year	% Change (+/-)	Trend
Access and Service Delivery				
Percent of families (working or not) who attest to improvement in access to care as a result of enabling policies and/or services [provider, employer, education level].				
Percent of children with untreated dental caries.				
Length of waiting time to access services.				
Percent of consumers reporting satisfaction with the services and assistance they receive.				
Assessments and Early Detection				
Percent of children who have dental sealants by age eight.				
Percent of children diagnosed with oral health conditions that have access to appropriate dental care, including education, prevention and treatment.				
Percent of children diagnosed with oral health disease that have access to appropriate dental care, including education, prevention and treatment.				

Children's Overall Health	Current Year	Benchmark Year	Change	Trend
Access and Service Delivery				
Percent of previously uninsured children who obtain some form of health insurance (Medicaid, private insurance, Nevada Check-Up).				
Percent of children who receive appropriate health care services as a result of screenings and/or other supportive services.				
Percent of children [with health coverage] who had at least one visit with a primary health provider in the past year.				
Prevalence of Chronic Illness				
Percentage of children engaged in vigorous physical activity regularly (e.g. 3 times per week).				
Percentage of children with obesity.				
Basic Needs				
Percentage of children with skipped meals or hunger due to lack of food (food insecurity).				
Percentage of children living at or below the poverty level.				
Percentage of children experiencing hunger who regularly utilize nutrition programs.				

Children's Overall Health	Current Year	Benchmark Year	Change	Trend
Percentage of families with children living in temporary shelters and/or housing.				
Substance Use and Abuse				
Percent of youth using tobacco, alcohol and other drugs in the last thirty days for one or more days.				
Injuries and Death				
The rate of preventable maltreatment, injuries and death among children and youth related to causes such as: motor vehicles, suicide attempts, guns, violence, and child abuse/neglect.				

Disability Services	Current Year	Benchmark Year	Change	Trend
Number and types of disabilities services that are culturally and linguistically appropriate.				
Percent of families (working or not) who attest to improvement in access to care as a result of policies and/or services [provider, employer, education level].				
Percent of individuals with speech/language/developmental delays receiving integrated services.				

Disability Services	Current Year	Benchmark Year	Change	Trend
Percent of individuals with disabilities who receive appropriate health care services as a result of screening, early diagnosis, and disease monitoring.				
Percent of individuals with disabilities who receive appropriate supportive services as a result of screenings.				

APPENDIX B: UNIVERSAL DATA SET

While Grantee's will opt for the tools most appropriate for their programs based upon the Uniform Measures they select, some basic information about persons served will be collected from all Grantees. This basic information will be summarized and reported quarterly by Grantees. The following universal data set will be incorporated into quarterly report forms for Grantees:

Universal Data Set

- Name
- Project Name
- City, State, Zip
- Contact Person
- Organization
- Email
- Phone
- Fax
- Reporting Period (MM/DD/YY to MM/DD/YY)
- Services Provided
- Grantee Goals
- Select Uniform Measures
- Quarterly Progress
- Year to Date Progress
- Number of enrolled clients/or number of clients reached
- Gender (Male/ Female)
- Ethnicity/Race

APPENDIX C: TOOL TEMPLATES

While Grantee's may or may not use the tools developed by the Evaluators to capture data about Uniform Measures, templates of the tools can be customized by Grantees. Templates available include:

Client Satisfaction Survey http://www.healthynevadaeval.com/pdf/OSS.pdf

Success and Sustainability Survey http://www.healthynevadaeval.com/pdf/SSS.pdf

Data Collection Workbook http://www.healthynevadaeval.com/pdf/DCT.pdf

- Client Profile Worksheet
- Service Delivery Worksheet
- Cost Benefit Worksheet

Tools

APPENDIX D: REQUIRED REPORTS

There are three reports that all Grantees must complete as a requirement of the Fund for a Healthy Nevada funding. They include: 1) Organizational self-assessment, 2) Quarterly Reports, and 3) an Annual Report. Templates for each of these reports are provided for grantees to utilize in the implementation of the evaluation plan.

Reports

Tools that have been developed and available for use include:

Organizational Self-Assessment Tool http://www.healthynevadaeval.com/pdf/OSA.pdf

Quarterly Reports – will be available from The Fund for a Healthy Nevada upon implementation

Annual Reports – will be available from The Fund for a Healthy Nevada upon implementation